

The Maltings Dental Practice

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Inspection Report

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Overall summary

We carried out an unannounced comprehensive inspection on 13 July 2016 to ask the practice the following key questions; Are services safe, effective, caring, responsive and well-led?

Our findings were:

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Are services responsive?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

Background

The practice is located in premises close to Grantham town centre. The practice provides a mixture of private and NHS dental treatments. Approximately 70% of the treatment is provided to NHS patients. There is a small car park to the front of the practice and disabled parking on the roadside outside for blue badge holders. There are twelve treatment rooms all of which are located on the ground floor.

The practice was first registered with the Care Quality Commission (CQC) in July 2011. The practice provides regulated dental services to both adults and children. Services provided include general dentistry, dental hygiene, crowns and bridges, and root canal treatment.

The practice's opening hours are - Monday: 8:45 am to 7 pm; Tuesday 8:45 am to 6:30 pm; Wednesday: 8:45 am to 5 pm; Thursday: 8:45 am to 5 pm; Friday: 8:45 am to 4 pm and alternate Saturdays from 9 am to 1 pm.

Access for urgent treatment outside of opening hours is by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could telephone the NHS 111 telephone number.

One of the partners is the registered manager. A registered manager is a person who is registered with the Care Quality Commission to manage the service. Like registered providers, they are 'registered persons'.

Summary of findings

Registered persons have legal responsibility for meeting the requirements in the Health and Social Care Act 2008 and associated Regulations about how the practice is run.

The practice has ten dentists; three oral surgeons; one orthodontist; and one practitioner with a special interest in orthodontics. four dental hygienists; twelve qualified dental nurses; two trainee dental nurses; six receptionists and a practice manager.

We received positive feedback from three patients about the services provided. This was by speaking with patients in the practice.

Our key findings were:

- There were systems in place to record accidents, significant events and complaints, and where learning points were identified these were shared with staff.
- The practice provided a sedation service for nervous patients or those requiring oral surgery. The guidance relating to sedation was being followed.
- The practice had the necessary equipment for staff to deal with medical emergencies, and staff had been trained how to use that equipment. This included an automated external defibrillator, oxygen and emergency medicines.
- The practice was visibly clean and tidy.
- The practice followed the relevant guidance from the Department of Health's: 'Health Technical Memorandum 01-05 (HTM 01-05) for infection control with regard to cleaning and sterilizing dental instruments.
- Records showed there were sufficient numbers of suitably qualified staff to meet the needs of patients.
- Dentists identified the different treatment options, and discussed these with patients.
- Patients' confidentiality was maintained.
- Patients said they had no difficulty getting an appointment that suited their needs.
- Patients we spoke with at the practice provided positive feedback about their experiences at the practice. Patients said they were treated with dignity and respect.
- The practice was well equipped and provided a relaxed atmosphere for patients.
- There was a whistleblowing policy accessible to all staff, who were aware of procedures to follow if they had any concerns.
- Patients were able to express their views and comments, and the practice listened to those views and acted upon them.

Summary of findings

The five questions we ask about services and what we found

We always ask the following five questions of services.

Are services safe?

We found that this practice was providing safe care in accordance with the relevant regulations.

The practice was visibly clean and spacious.

The practice provided a sedation service for nervous patients or those requiring oral surgery. This was both through intravenous medication into the patients' arm or through inhalation of a gas to help the patient relax. The guidance: Conscious Sedation in the Provision of Dental Care (Department of Health 2003) was being followed. The practice was working towards meeting the latest guidance published in April 2015 from the Royal College of Surgeons and the Royal College of Anaesthetists: 'Standards for Conscious Sedation in the Provision of Dental care.'

All staff had received up-to-date training in safeguarding vulnerable adults and children. There were clear guidelines for reporting concerns and the practice had a lead member of staff to offer support and guidance over safeguarding matters. Staff knew how to recognise the signs of abuse, and how to raise concerns when necessary.

The practice had emergency medicines and oxygen available, and an automated external defibrillator (AED). Regular checks were being completed to ensure the emergency equipment was in good working order.

The practice had infection control procedures to ensure that patients were protected from potential risks. Regular audits of the decontamination process were as recommended by the current guidance.

No
action


Are services effective?

We found that this practice was providing effective care in accordance with the relevant regulations.

All patients were clinically assessed by a dentist before any treatment began. The practice used a recognised assessment process to identify any potential areas of concern in a patient's mouth including their soft tissues (gums, cheeks and tongue).

The practice was following National Institute for Health and Care Excellence (NICE) guidelines for the care and treatment of dental patients. Particularly in respect of patient recalls, lower wisdom tooth removal and the prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart).

The practice had systems in place for making referrals to other dental professional when it was clinically necessary.

No
action


Are services caring?

We found that this practice was providing caring services in accordance with the relevant regulations.

Patient confidentiality was maintained and electronic dental care records were password protected.

Feedback from patients identified staff were friendly, polite and professional. Feedback indicated that the practice treated patients with dignity and respect.

There were systems for patients to be able to express their views and opinions.

No
action


Summary of findings

Are services responsive to people's needs?

We found that this practice was providing responsive care in accordance with the relevant regulations.

Patients who were in pain or in need of urgent treatment could usually get an appointment the same day.

Patient areas of the practice were located on the ground floor. There was good access for patients with restricted mobility, including level access. A disabled access audit in line with the Equality Act (2010) had been completed to consider the needs of patients with restricted mobility.

There were arrangements for emergency dental treatment outside of normal working hours, including weekends and public holidays which were clearly displayed in the waiting room, and the practice leaflet.

There were systems and processes to support patients to make formal complaints. Where complaints had been made these were acted upon, and apologies given when necessary.

No
action


Are services well-led?

We found that this practice was providing well-led care in accordance with the relevant regulations.

There was a clear management structure at the practice. Staff were aware of their roles and responsibilities within the dental team, and knew who to speak with if they had any concerns.

The practice had a robust system for carrying out regular audits to assess the safety and effectiveness of the services provided.

Patients were able to express their views and comments, and the practice listened to those views and acted upon them.

Staff said they could speak with a senior colleague if they had any concerns.

No
action


The Maltings Dental Practice

Detailed findings

Background to this inspection

We carried out this inspection under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the practice was meeting the legal requirements and regulations associated with the Health and Social Care Act 2008.

We carried out an unannounced, comprehensive inspection on 18 July 2016. This was following the Care Quality Commission (CQC) receiving information of concern. The inspection team consisted of a CQC inspector and a dental specialist advisor.

We reviewed the information we held about the practice and found there were no other areas of concern.

We reviewed policies, procedures and other documents. We received feedback from three patients about the dental service.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

These questions therefore formed the framework for the areas we looked at during the inspection.

Are services safe?

Our findings

Reporting, learning and improvement from incidents

The practice had systems for recording and investigating accidents, significant events and complaints. This allowed them to be analysed and any learning points identified and shared with the staff. Documentation showed the last recorded accident had occurred in April 2016 this being a minor injury to a member of staff. Action had been taken to reduce the likelihood of this happening again following the accident. Accident records went back over several years to demonstrate the practice had recorded and addressed issues relating to safety at the practice.

The practice had made a RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013) report in 2014. This was following an injury to a member of staff. RIDDOR is managed by the Health and Safety Executive, although since 2015 any RIDDORs related to healthcare have been passed to the Care Quality Commission (CQC). Staff said there had been no RIDDOR notifications made although they were aware how to make these on-line.

Records at the practice showed there had been nine significant events during 2016. The last recorded event had occurred in June 2016 and related to an issue related to items to be sent to the laboratory. The record showed all significant events had been analysed and discussed at staff meetings. We saw that incidents with both positive and negative outcomes were recorded and discussed.

The practice received Medicines and Healthcare products Regulatory Agency (MHRA) alerts. These were sent out centrally by a government agency (MHRA) to inform health care establishments of any problems with medicines or healthcare equipment. These were received by the practice manager analysed and shared with staff as appropriate.

Reliable safety systems and processes (including safeguarding)

The practice had a policy for safeguarding vulnerable adults and children. The policy had been reviewed and updated in February 2016. The policy identified how to respond to and escalate any safeguarding concerns.

Discussions with staff showed that they were aware of the safeguarding policies, knew who to contact and how to refer concerns to agencies outside of the practice when necessary.

There were two members of staff who were the identified lead for safeguarding in the practice. This being the senior nurse and a dentist/ partner They had received enhanced training in child protection to level three on 28 May 2014 to support them in fulfilling that role. We saw evidence that all staff had completed on-line safeguarding training during 2014.

The practice had a health and safety policy which made reference to the use and handling of chemicals in the practice. The policy had been reviewed and updated in February 2016. This identified the risks associated with the Control Of Substances Hazardous to Health (COSHH) Regulations 2002. The risk assessments identified the steps to take to reduce the risks including the use of personal protective equipment (gloves, aprons and masks) for staff, and the safe and secure storage of hazardous materials. The manufacturers' product data sheets were available in hard copy at the practice for staff reference. We saw that COSHH information had been reviewed and audited in January 2016.

The practice had an up to date Employers' liability insurance certificate which was due for renewal on 9 January 2017. Employers' liability insurance is a requirement under the Employers Liability (Compulsory Insurance) Act 1969.

The practice had a sharps policy which informed staff how to handle sharps (particularly needles and sharp dental instruments) safely. The policy had been reviewed in February 2016. We saw the practice used a recognised system for handling sharps safely in accordance with the Health and Safety (Sharp Instruments in Healthcare) Regulations 2013, and practice policy. Practice policy was that only dentists handled sharp instruments.

There were sharps bins (secure bins for the disposal of needles, blades or any other instrument that posed a risk of injury through cutting or pricking.) We saw the sharps bins were attached to the wall in clinical areas which followed the guidance which indicated sharps bins should not be located on the floor, and should be out of reach of small children.

Are services safe?

Discussions with dentists and a review of patients' dental care records identified the dentists were using rubber dams when carrying out root canal treatments. Guidelines from the British Endodontic Society recommend that dentists should be using rubber dams. A rubber dam is a thin rubber sheet that isolates selected teeth and protects the rest of the patient's mouth and airway during treatment. We saw the practice had a supply of rubber dam kits in the practice including latex free rubber dams. In addition we saw X-ray evidence that rubber dams had been used at the practice.

Medical emergencies

The dental practice had equipment in preparation for any medical emergencies that might occur. This included emergency medicines and oxygen which were located in a secure central location. We checked the medicines and found they were all in date.

There was a first aid box in the practice and we saw evidence the contents were being checked regularly. Six members of staff had completed a first aid at work course we saw certificates to evidence the staff had completed the training. Information was placed in the waiting room to inform patients of the location of the first aid boxes and who the trained first aid staff were at the practice.

There was an automated external defibrillator (AED) at the practice. An AED is a portable electronic device that automatically diagnoses life threatening irregularities of the heart and delivers an electrical shock to attempt to restore a normal heart rhythm. The AED was being checked regularly to ensure it was working correctly. This complied with the Resuscitation Council UK guidelines.

All staff at the practice had completed basic life support and resuscitation training on 27 January 2016. Immediate life support training had been completed by staff involved in sedation at the practice on 25 November 2015.

Additional emergency equipment available at the practice included: airways to support breathing, oxygen masks for adults and children, manual resuscitation equipment (a bag valve mask) and portable suction.

Discussions with staff identified they understood what action to take in a medical emergency. Staff said they had received training in medical emergencies.

Staff recruitment

We looked at the staff recruitment files for five staff members to check that the recruitment procedures had been followed. The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 identifies information and records that should be held in all staff recruitment files. This includes: proof of identity; checking the person's skills and qualifications; that they are registered with professional bodies where relevant; evidence of good conduct in previous employment and where necessary a Disclosure and Barring Service (DBS) check was in place (or a risk assessment if a DBS was not needed). DBS checks identify whether a person has a criminal record or is on an official list of people barred from working in roles where they may have contact with children or adults who may be vulnerable.

We found that all members of staff had received a DBS check. We discussed the records that should be held in the recruitment files with the practice manager and saw the practice recruitment policy and the regulations had been followed.

Monitoring health & safety and responding to risks

The practice had a health and safety policy which had been reviewed in February 2016. The policy identified individual members of staff who had set responsibilities within the practice for different areas of health and safety. As part of this policy environmental risk assessments had been completed. For example there were risk assessments for: waste disposal and latex.

Records showed that fire extinguishers had been serviced in December 2015. Records showed the practice had a fire drill on 13 January 2016 and these were routinely scheduled for every six months. All staff also completed fire training as part of their induction. We saw that fire procedures were discussed at staff meetings following fire drills at the practice.

The practice had a health and safety law poster on display in the staff corridor. Employers are required by law (Health and Safety at Work Act 1974) to either display the Health and Safety Executive (HSE) poster or to provide each employee with the equivalent leaflet.

The practice provided both an inhalation (using a gas to relax the patient such as nitrous oxide) and an intravenous sedation service (using a medicine introduced via a vein to help the patient relax). Staff said sedation was most often used to support patients during surgical procedures such

Are services safe?

as tooth removal. In April 2015, the Royal College of Surgeons and the Royal College of Anaesthetists published guidance on 'Standards for Conscious Sedation in the Provision of Dental care.' We saw the practice were working towards meeting the newer standards. However, the practice was meeting the standards set out in the previous guidance: Conscious Sedation in the Provision of Dental Care (Department of Health 2003). Patients were assessed at an initial appointment where the treatment plan was discussed including the costs. This allowed time for the patient to consider the risks and benefits of the sedation procedure as explained by the oral surgeon. This also gave the opportunity for patients to withdraw if they so wished. Patients were provided with written guidance for before and after the sedation. A pre-operation appointment was also arranged for patients who were receiving intravenous sedation to carry out observations such as blood pressure and blood sugar levels. The practice required that an escort come with the patient on the day that sedation was scheduled. This was to safeguard the patient afterwards and on their way home. The escort was formally briefed by the practice staff on their duties, and given a leaflet which provided all of the necessary information. They were required to remain in the practice throughout the sedation procedure. The sedationist was supported by trained staff and resuscitation equipment was available. Staff who were involved in providing the sedation service had completed immediate life support training. Sedation was achieved with a single medicine called Midazolam. A reversal agent called Flumazenil was available if required.

Infection control

Dental practices should be working towards compliance with the Department of Health's guidance, 'Health Technical Memorandum 01-05 (HTM 01-05): Decontamination in primary care dental practices' in respect of infection control and decontamination of equipment. This document sets out clear guidance on the procedures that should be followed, records that should be kept, staff training, and equipment that should be available.

Prior to this inspection we had been made aware of concerns relating to infection control. These were particularly in respect of staff uniforms. However, we saw no evidence of this during the inspection. Every member of staff we met was wearing a clean uniform and was dressed appropriately.

The practice had an infection control policy which had been reviewed in February 2016. A copy of the site specific policy was available to staff in the decontamination room. Dental nurses had set responsibilities for cleaning and infection control in each individual treatment room. The practice had systems for testing and auditing the infection control procedures.

Records showed that regular six monthly infection control audits had been completed. This was as recommended in the guidance HTM 01-05. The last audit was completed on 25 April 2016 and scored 99%.

The practice had a clinical waste contract, and waste matter was collected regularly. Clinical waste was stored securely away from patient areas while awaiting collection. A clinical waste contract with a different company covered the collection of amalgam, a type of dental filling which contains mercury and is therefore considered a hazardous material. The practice had spillage kits for mercury and bodily fluids. The mercury spillage kit was undated and arrangements were made to replace the kit during the inspection.

There were two decontamination rooms, one at each end of the building. This was where dental instruments were cleaned and sterilised. Staff wore personal protective equipment during the process to protect themselves from injury. This included the use of heavy duty gloves, aprons and protective eye wear. Staff demonstrated an awareness of latex allergy and alternative latex free gloves were available.

We saw that instruments were being cleaned and sterilised at the practice. A dental nurse demonstrated the decontamination process. We saw the procedures were as outlined in the published guidance (HTM 01-05).

The practice had three ultrasonic baths. An ultrasonic bath is a piece of equipment specifically designed to clean dental instruments through the use of ultrasound and a liquid. After cleaning instruments were rinsed and examined using an illuminated magnifying glass. Finally the instruments were sterilised in one of the practice's two autoclaves (devices for sterilising dental and medical instruments). The practice had one steam autoclave which was designed to sterilise unwrapped or solid instruments and one vacuum autoclave which was designed to sterilise

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wrapped dental instruments. The practice maintained a third autoclave as a backup machine. At the completion of the sterilising process, all instruments were dried, placed in pouches and dated with a use by date.

We checked the equipment used for cleaning and sterilising the dental instruments was maintained and serviced regularly in accordance with the manufacturers' instructions. There were records to demonstrate this and that equipment was functioning correctly. Records showed that the equipment was in good working order and being effectively maintained.

We noted that the wallpaper in both decontamination rooms was peeling away from the wall which presented a potential infection control risk. We brought this to the attention of the practice manager who said both decontamination rooms were due to be redecorated and the issue with the peeling wallpaper would be addressed.

The practice had a policy for dealing with blood borne viruses. There were records to demonstrate that clinical staff had received inoculations against Hepatitis B and had received blood tests to check the effectiveness of that inoculation. Health professionals who are likely to come into contact with blood products, or who are at increased risk of sharps injuries should receive these vaccinations to minimise the risk of contracting blood borne infections.

The practice had a risk assessment for dealing with the risks posed by Legionella. This had been completed by an external contractor in September 2015. Legionella is a bacterium found in the environment which can contaminate water systems in buildings. The practice was aware of the risks associated with Legionella and had taken steps to reduce them with regular flushing of dental water lines as identified in the relevant guidance. The practice had an identified member of staff who had completed Legionella training and who oversaw the practice's Legionella risk management.

Equipment and medicines

The practice kept records to demonstrate that equipment was maintained and serviced in line with manufacturer's guidelines and instructions. Portable appliance testing (PAT) had been completed on electrical equipment at the practice in October 2013. Visual checks had been completed on an annual basis and a full PAT test was due in October 2016. The gas boiler had been serviced on 21 October 2015. Documentation showed the fire alarm and

emergency lights had been serviced in February 2016. The pressure vessel checks on the compressor which produced the compressed air for the dental drills had been completed in March 2016.

The practice had all of the medicines needed for an emergency situation, as recommended in the British National Formulary (BNF).

Emergency medical equipment was monitored regularly to ensure it was in working order and in sufficient quantities.

Radiography (X-rays)

There was a Radiation Protection file which contained the relevant information and records relating to the X-ray machines and their safe use on the premises.

The practice had two intraoral X-ray machines (intraoral X-rays concentrate on one tooth or area of the mouth) There was also one extra-oral X-ray machine (an orthopantomogram known as an OPG) for taking X-rays of the entire jaw and lower skull.

X-rays were carried out in line with local rules that were relevant to the practice and specific equipment. The local rules for the use of each X-ray machine were available in each area where X-rays were carried out.

The Radiation Protection file identified the practice had a radiation protection supervisor (RPS) this being the dentists. The provider had appointed an external radiation protection advisor (RPA). This was a company specialising in servicing and maintaining X-ray equipment, who were available for technical advice regarding the machinery. The Ionising Radiation Regulations 1999 (IRR 99) requires that an RPA and an RPS be appointed and identified in the local rules. Their role is to ensure the equipment is operated safely and by qualified staff only.

Records showed the X-ray equipment had last been inspected in March 2016. The Ionising Radiation Regulations 1999 (IRR 99) require that X-ray equipment is inspected at least once every three years. The regulations also required providers to inform the Health and Safety Executive (HSE) that X-rays were being carried out on the premises. Documentary evidence dated 10 February 2000 confirmed this had been completed.

Are services safe?

The practice used digital X-rays, which allowed the image to be viewed almost immediately, and relied on lower doses of radiation. This therefore reduced the risks to both the patients and staff.

All patients were required to complete a medical history form and the dentist considered each patient's individual circumstances to ensure it was safe for them to receive X-rays. This included identifying where patients might be pregnant. There were risk assessments in place for pregnant and nursing mothers.

Patients' dental care records showed that information related to X-rays was recorded in line with guidance from the Ionising Radiation (Medical Exposure) Regulations 2000. This included grading of the X-ray, views taken, justification for taking the X-ray and the clinical findings. We saw that the Faculty of General Dental Practice (FGDP UK) guidelines: 'selection criteria for dental radiography' (2013) were being followed.

Are services effective?

(for example, treatment is effective)

Our findings

Monitoring and improving outcomes for patients

The practice held electronic dental care records for each patient. Dental care records contained information about the assessment, diagnosis, and treatment and also recorded the discussion and advice given to patients by dental healthcare professionals. The care records showed a thorough examination had been completed, and identified with risk factors such as smoking and diet for each patient.

Patients at the practice completed a medical history form, or updated their details. The patient signed the medical history form to confirm their medical details. The patients' medical histories included any health conditions, medicines being taken and whether the patient had any allergies.

The dental care records showed that dentists assessed the patients' periodontal tissues (the gums) and soft tissues of the mouth. The dentists used the basic periodontal examination (BPE) screening tool. BPE is a simple and rapid screening tool used by dentists to indicate the level of treatment needed in relation to a patient's gums.

We saw dentists used national guidelines on which to base treatments and develop treatment plans for managing patients' oral health. Discussions with dentists showed they were aware of National Institute for Health and Care Excellence (NICE) guidelines, particularly in respect of recalls of patients, prescribing of antibiotics for patients at risk of infective endocarditis (a condition that affects the heart) and wisdom tooth removal. A review of the records identified that the dentists were following NICE guidelines in their treatment of patients.

Health promotion & prevention

The practice had one waiting room. The waiting room had recently been refurbished and as a result posters and leaflets relating to good oral health and hygiene had not been removed and not replaced in waiting room. We saw that leaflets were available in the treatment rooms about common treatments and conditions relating to the mouth. A flat screen television provided information and positive oral health messages. Services offered at the practice were identified and there was information for parents about caring for their children's teeth.

The practice engaged with the local community and this included visits to local schools. Two members of staff had oral health education qualifications. The senior nurse co-ordinated visits to schools with approximately one visit per month. This gave staff the opportunity to discuss good oral hygiene and diet with the children. The practice had also visited a local care home for older people to talk with staff about maintaining good oral hygiene.

Children seen at the practice were offered fluoride application varnish and fluoride toothpaste if they were identified as being at risk. This was in accordance with the government document: 'Delivering better oral health: an evidence based toolkit for prevention.' This has been produced to support dental teams in improving patients' oral and general health. Discussions with dentists showed they had a good knowledge and understanding 'delivering better oral health' toolkit.

We saw detailed examples in patients' dental care records that dentists had provided advice on the harmful effects of smoking, alcohol and diet and their effect on oral health. With regard to smoking, dentists had particularly highlighted the risk of dental disease and oral cancer.

Staffing

The practice had ten dentists; three oral surgeons; one orthodontist; and one practitioner with a special interest in orthodontics. four dental hygienists; twelve qualified dental nurses; two trainee dental nurses; six receptionists and a practice manager. Before the inspection we checked the registrations of all dental care professionals with the General Dental Council (GDC) register. We found all staff were up to date with their professional registration with the GDC.

Records within the practice showed there were sufficient numbers of staff to meet the needs of patients attending the practice for treatment.

We looked at staff training records for four staff members and these showed that staff were maintaining their continuing professional development (CPD). CPD is a compulsory requirement of registration with the GDC. The training records showed how many hours training staff had undertaken together with training certificates for courses attended. This was to ensure staff remained up-to-date and continued to develop their dental skills and knowledge. Examples of training completed included: radiography (X-rays) and we saw certificates to evidence staff had

Are services effective?

(for example, treatment is effective)

attended a minimum of five hours training within the required minimum period of five years. We also saw certificates to evidence that medical emergencies, infection control, and safeguarding had all been included in the CPD cycle for staff.

Records at the practice showed that annual appraisals were booked for all staff in July 2016. As part of the appraisal process staff completed a personal development plan to identify training needs and behaviours for the coming year. We also saw evidence of new members of staff having an induction programme.

Working with other services

The practice was equipped to provide oral surgery with three oral surgeons on the staff at The Maltings. Therefore referrals were received from other dentists and dental professionals where the oral surgery was beyond their experience or capacity. The practice also took referrals that were identified as 'difficult or complicated cases' this included where the patient required sedation. The practice had an orthodontist on the staff and therefore also received referrals for orthodontic work from other dental practices in the area. Staff said the most likely circumstances where a referral would be made from the practice would be if the treatment was best carried out in hospital. That decision would be taken based on risk and the patients' view of the situation.

Consent to care and treatment

The practice had a consent policy which had been reviewed in February 2016. The policy made reference to the Mental Capacity Act 2005 (MCA). The issue of capacity was explored within the policy and this included making best interest decisions as identified in the MCA. The MCA provides a legal framework for acting and making decisions on behalf of adults who lacked the capacity to make particular decisions for themselves.

Consent was recorded in the patients' dental care records. The dentists discussed the treatment plan, and explained the process, which allowed the patient to give their informed consent.

We saw how consent was recorded in the patients' dental care records. Dentists had discussed the treatment plan with the patients, which then allowed patients to give their informed consent. Dentists used a consent form and treatment plan to record consent. A copy was given to the patient for their records.

The consent policy made reference to obtaining consent from children under the age of 18. We talked with dentists about this and identified they were aware of Gillick competency. This refers to the legal precedent set that a child may have adequate knowledge and understanding of a course of action that they are able to consent for themselves without the need for parental permission or knowledge.

Are services caring?

Our findings

Respect, dignity, compassion & empathy

Throughout the inspection we observed staff when they were speaking with patients. We saw that staff were polite, friendly and professional. We saw that patients were treated with dignity and respect.

The reception desk was located within the waiting room. We asked reception staff how patient confidentiality was maintained. Staff said if it were necessary to discuss a confidential matter, there were usually an unused treatment room available for this purpose. Staff said that details of patients' individual treatment were not discussed at the reception desk.

We saw examples that showed patient confidentiality was maintained at the practice. For example we saw that computer screens could not be overlooked at the reception desk. In addition patients' dental care records were password protected and held securely.

Involvement in decisions about care and treatment

We received positive feedback from three patients about the services provided. This was through speaking with patients at the practice.

The practice offered mostly NHS treatments (70%) and the costs were clearly displayed in the practice. However, the practice website only displayed the costs of private treatment and finance arrangements.

We spoke with two dentists about how each patient had their diagnosis and dental treatment discussed with them. The dentists demonstrated in the patient care records how the treatment options and costs were explained and recorded. Patients were given a written copy of the treatment plan which included the costs.

Where necessary dentists gave patients information about preventing dental decay and gum disease. Dentists had highlighted the particular risks associated with smoking and diet, and we saw examples of this recorded in the dental care records. Patients were monitored through follow-up appointments in line with National Institute for Health and Care Excellence (NICE) guidelines. There were posters in the practice explaining the NICE guidelines in respect of recalls for appointments.

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

The practice was located in ground floor premises close to the centre of Grantham. There was a small car park at the front of the practice. Alternatively a pay and display car park was located within yards of the practice. There were twelve treatment rooms all located at ground level.

The practice had separate staff and patient areas, to assist with confidentiality and security.

We saw there was a good supply of dental instruments, and there were sufficient instruments to meet the needs of the practice.

Staff said that when patients were in pain or where treatment was urgent the practice made efforts to see the patient the same day. To facilitate this the practice made specific appointment slots available for patients who were in pain.

We reviewed the appointment book, and saw that patients were allocated sufficient time to receive their treatment and have discussions with the dentist.

Tackling inequity and promoting equality

There was an equal opportunities policy which had been reviewed in February 2016.

The practice was situated over two floors with all patient areas on the ground floor. This allowed patients who used a wheelchair or with restricted mobility easy access treatment at the practice. The treatment rooms were large enough for patients to manoeuvre a wheelchair or push chair.

The practice had two ground floor toilets one of which adapted for the use of patients with mobility problems. The toilet had support bars, grab handles and an emergency pull cord. Taps on the hand wash sink were lever operated and there was a hot air hand dryer. The side door of the practice was accessible to patients in a wheelchair via a removable ramp. A door bell was available to alert staff a patient with mobility issues required access.

We saw a copy of an access audit completed in line with the Equality Act (2010) this had been reviewed and updated

in February 2016. This identified the practice was compliant with legislation relate to access in the Equality Act. The practice had a portable hearing induction loop in reception to assist patients who used a hearing aid. The Equality Act requires where 'reasonably possible' hearing loops are to be installed in public spaces, such as dental practices.

The practice had access to a recognised company to provide interpreters, and this included the use of sign language. Details were available to staff at the reception desk. We saw evidence in dental care records of a patient who had accessed an interpreter during their treatment.

Access to the service

The practice's opening hours were - Monday: 8:45 am to 7 pm; Tuesday 8:45 am to 6:30 pm; Wednesday: 8:45 am to 5 pm; Thursday: 8:45 am to 5 pm; Friday: 8:45 am to 4 pm and alternate Saturdays from 9 am to 1 pm.

Access for urgent treatment outside of opening hours was by telephoning the practice and following the instructions on the answerphone message. Alternatively patients could telephone the NHS 111 number.

The practice operated a text message reminder service with patients receiving a text two days before their appointment was due.

Concerns & complaints

The practice had a complaints procedure which had been reviewed in February 2016. The procedure explained how to complain and included other agencies to contact if the complaint was not resolved to the patients satisfaction.

Information about how to complain was contained in the patient information folder in the waiting room, and was available on the practice website.

From information received before the inspection we saw that there had been six formal complaints received in the 12 months prior to our inspection. The documentation showed the complaints had been handled appropriately and an apology and an explanation had been given to the patient.

Are services well-led?

Our findings

Governance arrangements

We saw a number of policies and procedures at the practice and saw they had been reviewed and where relevant updated during February 2016. The practice manager identified that all policies were updated on an annual basis.

We spoke with staff who said they understood the structure of the organisation. Staff said if they had any concerns there were identified staff with whom they could discuss their concerns. This included access to clinical staff if their concerns related to clinical practice. We spoke with two members of staff who said they liked working at the practice and there was a good staff team.

We saw a selection of dental care records to assess if they were complete, legible, accurate, and secure. The dental care records we saw contained sufficient detail and identified patients' needs, care and treatment.

Leadership, openness and transparency

There was a practice manager in post who had been in post for several years. They were studying for a diploma in management to level four.

We saw that there were regular staff meetings at the practice. The agenda covered areas such as: infection control, and health and safety. Staff meetings were minuted and minutes were available to all staff. When there were learning points to be shared with staff we saw evidence these had been discussed and shared as appropriate.

Our observations demonstrated there was a professional and welcoming attitude towards patients from staff throughout the practice. Discussions with different members of the staff team showed staff had a good understanding and knowledge of policies and procedures within the practice.

The practice had a whistleblowing policy which had been reviewed in February 2016. The whistleblowing policy identified how staff could raise any concerns they had about colleagues' conduct or clinical practice. This was both internally and with identified external agencies. A copy of the policy was available on any computer in the practice. A hard copy was available in the office.

Learning and improvement

The practice was a training practice for foundation dentists. These are dentists who are in the final year of their training. They spend a year working in a practice under supervision to gain hands on experience.

To monitor the quality of the service we saw there were audits were throughout the year. This was for clinical areas of the practice. The audits identified both areas for improvement, and where quality had been achieved. Examples of completed audits included: X-ray (radiographs); patient recalls (to ensure they were following NICE guidelines); dental care records and patient satisfaction.

Clinical staff working at the practice were supported to maintain their continuing professional development (CPD) as required by the General Dental Council. Training records at the practice showed that clinical staff were completing their CPD and the hours completed had been recorded. Dentists are required to complete 250 hours of CPD over a five year period, while other dental professionals need to complete 150 hours over the same period.

Practice seeks and acts on feedback from its patients, the public and staff

The practice had a NHS Friends and Family Test (FFT) comment box which was located in the waiting room. The FFT is a national programme to allow patients to provide feedback on the services provided. The FFT comment box was being used specifically to gather regular feedback from NHS patients, and to satisfy the requirements of NHS England. The latest information on the NHS Choices website showed six patients had responded and 100% said they would recommend the practice to their family and friends. We saw staff meeting minutes which showed FFT information was discussed on a monthly basis.

The NHS Choices website: www.nhs.uk had two patient reviews in the year up to this inspection and three in total. All three reviews provided positive comments.

The practice operated its own satisfaction survey on an annual basis. Twenty patients were asked to provide feedback for each dentist. We saw the results of the 2015 survey had been analysed and the findings were discussed in a staff meeting.